The Partnership for Maternal, Newborn & Child Health

Workshop on health care professional associations (HCPAs) and their role in achieving MDGs 4 and 5

November 2008
Dhaka, Bangladesh
Meeting report

Contents

List of Acronyms

AMA	Afghan Midwifery Association
APA	Afghan Pediatric Association
ASHA	Accredited Social Health Activist
ASOG	Afghan Society of Obstetricians and Gynecologists
AusAID	Australia Agency for International Development
BNC	Bangladesh Nursing Council
BPA	Bangladesh Pediatric Association
CSBA	Community skilled birth attendant
CSBAP	Community skilled birth attendant program
CWCH	Centre for Woman and Child Health
FIGO	International Federation of Gynaecology and Obstetrics
FIP	International Pharmaceutical Federation
FOGSI	Federation of Obstetric and Gynecological Societies of India
HCP	Health care professionnal
HCPA	Health care professionals association
IAP	Indian Academy of Paediatrics
ICM	International Confederation of Midwives
IMCI	Integrated Management of Childhood Illnesses
LHWP	Lady Health Worker Programme of Pakistan
MAN	Midwifery Association of Nepal
MAP	Midwifery Association of Pakistan
MDG	Millennium Development Goal
MNC	Maternal, newborn and child
MNCH	Maternal, newborn and child health
MoH	Minister of Health
NAA	Nursing Association of Afghanistan
NESOG	Nepal Society for Obstetricians and Gynecologists
NGO	Non governmental organization
NNF	National Neonatology Forum
NPA	Nepal Pharmaceutical Association
OGSB	Obstetric and Gynecological Society of Bangladesh
PMNCH	Partnership for Maternal, Newborn and Child Health
PPH	Post Partum Haemorrhage
SHPP	Society of Hospital Pharmacists of Pakistan
SOGP	Society of Obstetrics and Gynecology of Pakistan
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

I - Workshop Summary and Highlights

The third in a series of Health Care Professional (HCP) Workshops was held from 22 to 25 November 2008 in Dhaka, Bangladesh, bringing together representatives of HCP Associations (HCPAs) from six countries in the South Asian region (Afghanistan, Bangladesh, India, Myanmar, Nepal, and Pakistan). The objective of the Workshop – developed on the basis of recommendations stemming from a September 2006 meeting involving The Partnership for Maternal Newborn and Child Health (PMNCH) and its Health Care Professional Advisory Group – was to strengthen the ability of participating HCPAs to engage in advocacy activities, and in the planning and implementation of programs and policies relevant to the achievement of Millennium Development Goals Four and Five. The Workshop format was divided into two parts, the first provided a forum for the sharing of best practices and success stories through plenary sessions and panel discussions, and the second focused on group work resulting in the production of country action plans to guide joint HCPA activities in the next one-two years.

The Workshop was attended by a range of health care professionals from associations varying in size, experience, and organizational strength. The participation level of donors and international organizations was also high and included representation from AusAID, USAID, WHO, UNFPA and UNICEF among others. However, low participation from Ministries of Health indicate the need for greater advocacy work to ensure governments in the six participating countries are informed of the benefits of involving HCPAs in the design and introduction of MNCH related programs and policies.

In the first half of the Workshop, participants learned about Pakistan's Lady Health Worker Program which has contributed to substantial reductions in maternal mortality through the scale-up of community health workers. Other success stories described included HCPAs in Bangladesh and Afghanistan working with government officials to expand training opportunities (e.g., to increase the number of skilled birth attendants and midwives, respectively), and a fistula project in Pakistan responsible for improving the demand for and availability of emergency obstetrical care and fistula treatment services at the community level. In addition, the representatives from Indian HCPAs presented a number of positive examples of how HCPAs can become well-organized, sufficiently resourced, and highly influential in MNCH-related activities.

The first portion of the Workshop also provided an opportunity for attendees to foster networks, identify common concerns and objectives, and begin prioritizing actions that could be jointly addressed at the regional level. For example, all participants agreed that the unequal distribution of health workers poses a challenge to the equitable delivery of services, particularly in areas of greatest need such as urban slums and remote localities. Other shared problems included insufficient government involvement and funding, dependency on unstable donor funding, inefficient use of available funds, and the need for advocacy activities geared towards changing service provider attitudes and creating higher demand at the community level.

During the second portion of the workshop, participants pledged to form national HCPA coalitions in their home countries with the objective of working together towards the achievement of MDGs 4 and 5. Another key outcome of the second half of the workshop included the development of country action plans consisting of feasible and measurable tasks to be accomplished within the next 1-2 years.

An additional highlight of the Workshop was the high representation of pharmaceutical associations and the acknowledgement of all in attendance of the importance of involving pharmacists and anaesthesiologists in joint HCPA activities. The Workshop also marked the first time pediatricians, obstetricians, pharmacists, midwives, nurses and members of the Ministry of Health from Afghanistan were able to convene and work together.

II - Opening Ceremony, 22 November 2008

Dr Mushtaque Chowdhury of the Bangladesh Rural Advancement Commission presided over the opening ceremony.

Dr Zulfiquar Bhutta, representative of the International Academy of Pediatrics, opened the Workshop by presenting an overview of the role of HCPAs in achieving MDGs 4 and 5, and background information on the joint efforts of PMNCH and its Health Care Professional Advisory Group to catalyze greater HCPA involvement in the planning and implementation of MNCH related programs and policies. He emphasized the need for HCPAs to form partnerships among themselves and with other MNCH stakeholders to best advocate for and contribute to the design and scale-up of proven MNCH interventions. Dr Bhutta concluded his speech by outlining the aims of the workshop including a commitment of those in attendance to work together towards the improvement of MNCH in their respective countries and in the South Asian region.

Dr Andres de Francisco, speaking on behalf of the Director of The Partnership, began his presentation with a description of the current global MNCH situation, highlighting the high and growing burden of MNC deaths in Africa and Asia and the inverse relationship between health worker density and maternal and newborn deaths. Focusing on the Asian context, Dr de Francisco identified low coverage of proven interventions, lack of political advocacy, inequities and inefficiencies in service provision, and the widespread human resource crisis as key reasons for the region's insufficient progress towards MDGs 4 and 5. He ended his presentation by providing a synopsis of the history and mandate of the PMNCH including its collaborations with its Health Care Professional Advisory Group, and the events leading to the development of the HCPA workshops.

Dr Zafrullah Chowdhury, representative of Gonoshasthya Kendra, delivered the keynote address. He explained that MDGs 4 and 5 are achievable through innovation, a broadening of the scope of actors involved in MNCH related activities, and a greater focus on reaching the poor. Dr Chowdhury highlighted the importance of developing a systematic approach to targeting underserved population groups and creating solutions to current disparities in the distribution of health workers. He challenged HCPAs to review training programs to determine how they can be made more accessible and less time consuming, and identify ways of collaborating with the private sector. He also urged HCPAs to work towards making health care professionals more accountable to patients, and programs more sustainable (e.g., through insurance and other payment schemes, and by increasing the accessibility of services, etc.).

Professor Abul Faiz, Director General of Health Services of Bangladesh, reiterated Dr Chowdhury's message on the importance of innovation for achieving MDGs 4 and 5, and added the centrality of community-based strategies for improving maternal, newborn, and child survival. He encouraged HCPAs to work with their governments to identify which low cost interventions are most needed, and how they can be best implemented and brought to scale. He also pointed out the need for greater advocacy on MNCH, a focus on addressing gaps in service provision along the continuum of care, increased involvement of youth in MNCH, and more training opportunities for health care professionals.

III - Day One Activities, 23 November 2008

Professor Zulfiquar Bhutta, Aga Khan University and representative of the International Paediatric Association, launched the activities of the first portion of the Workshop by detailing South Asia's progress towards MDGs 4 and 5. He noted the growing proportion of maternal and child deaths in the region, linking these deaths to widespread under-nutrition and micro-nutrient deficiencies. Specifically, he described South Asia's elevated prevalence rates of underweight and stunted children, and the high numbers of pregnant women suffering from anaemia. He also pointed out that low coverage levels of proven MNCH interventions, poor coverage of adequate water and sanitation facilities, low health worker densities, inequities in access to health care, weak referral systems, and rapid growth of urban slums are all factors contributing to the excess maternal and child deaths in the region.

Dr Bhutta next outlined strategies for moving forward. He encouraged HCPAs to concentrate on providing a mix of effective interventions which can be realistically implemented and target poorer districts where most deaths occur. He also advised that increasing the number of health care professionals should be a secondary goal to addressing the problem of the inequitable distribution of health care professionals, and stressed the importance of making the private sector a part of the solution to the human resource crisis. In addition, Dr Bhutta listed the need for research into why some poor districts 'do better' than others.

Turning to the role health care professionals should play in the advancement of MNCH, Dr Bhutta stressed that HCPAs need to begin working in partnership on activities related to country support, advocacy, capacity building, and technical innovations:

- working with the government to develop integrated MNCH plans and make MNCH part of the evaluation framework for determining the overall efficiency of the health system;
- building links between academia and training institutions;
- influencing policy in regards to curriculum and training opportunities;
- developing training courses jointly with governments to avoid duplication;
- designing models for the sustainable delivery of care in the public sector;
- conducting needs assessments and monitoring and evaluation activities;
- developing evidence-based guidelines/standards.

After presenting a case study of Pakistan, Professor Bhutta concluded his presentation by asking those in attendance to agree on the top 10 interventions that need to be implemented across the South Asian region, using this list as a framework for moving forward.

The following recommendations were made during the discussion session:

- anaesthesiologists should be asked to participate in future HCPA workshops;
- a government mandated compulsory rural assignment could be a potential means of addressing the unequal distribution of health care workers;
- efforts to improve the quality of working conditions in urban slums and remote areas also need to be made including ensuring the provision of adequate support and supervision;
- efforts to improve the absorption of existing funds should be made in tandem with activities to secure additional funds;
- HCPs should agree on a list of key interventions most critical to implement in the short term, and identify associated coverage indicators for monitoring and evaluation purposes;
- increases in demand must be met by improvements in the quality and availability of services. People should not be forced to seek substandard care.

3.1 Organizational Strengthening

3.1.1 Presentation

Dr Neelam Kler, President Elect of the National Neonatology Forum of India presented on the MNCH situation in India and the history and current activities of the National Neonatology Forum and the Indian Academy of Paediatrics,.

Dr Kler began the presentation by reviewing India's epidemiological context, highlighting the country's persisting health inequities in access to care and MNC mortality outcomes. She then described the Indian Academy of Paediatrics, an association consisting of 17,500 members and 3 central, 26 state and 300 district level offices. In her review of the organization, Dr Kler identified the following growth areas where achievements have been made but where improvements are also needed:

- evidence generation for the formulation of appropriate policies;
- advocacy targeted at donors, the public sector, members of the Academy itself (to improve attendance at IAP conferences);
- education and information sharing through numerous publications, textbooks, training manuals and parent education literature;
- capacity building and training, especially in regards to training trainers and networking;
- grassroots implementation to reach a wider audience including the non-literate population.

Dr Kler also listed lack of funding, ownership and motivation as major constraints to the greater involvement of the IAP in public health activities.

During the second half of the presentation, Dr Kler described the National Neonatology Forum (NNF), an organization established in 1980 with the objective of generating new knowledge and guidelines for the practice of neonatology. She stressed that in order for India to attain its MDG 4 target, greater attention needs to be directed at the neonatal period which is accounting for a growing proportion of all under five deaths as overall child mortality levels decrease. The main activities of the NNF are the publication of the Journal of Neonatology, the hosting of conferences, training activities, and the establishment of guidelines and accreditation of newborn units. As in the case of the IAP, the growth areas for the NNF include involvement in policy and program development (e.g., the NNF served as a member of the National Technical Committee, and is currently involved in a joint venture with UNICEF on developing a facility based approach to the provision of comprehensive newborn care), teaching and training (e.g., training related to the National resuscitation program and the provision of neonatal advanced life support, the development of the ASHA module for community health workers), advocacy (e.g. involvement in the National Newborn Week and promotion of the inclusion of the neonatal component into IMCI) , and the establishment of effective partnerships with the private sector.

3.1.2 Panel

The panel was chaired by Imtiaz Kamal of the Midwifery Association of Pakistan. Panelists included Dr Hiralal Konar, representative of the Federation of Obstetric and Gynecological Societies of India (FOGSI), Dr Sayeba Akhter, representative of the Obstetric and Gynecological Society Bangladesh, Dr Samuel Hla, representative of the Pediatric Society of Myanmar and Ms Guljan Jalal, representative of the Nursing Association of Afghanistan (NAA).

Dr Konar commented on the media capability and advocacy work of FOGSI, with 27 000 members. He also mentioned the difficulties of coordinating messages at state and community levels, an issue that could be resolved with greater government involvement. Mrs Jalal spoke of the challenges faced by the NAA in developing curricula and training programs for nurses, notably chronic budget shortfalls. Mrs Kamal reinforced the need for a teamwork approach across all HCPs.

3.2 Planning

The goal of the session was to learn from the experiences of participating HCPAs about how to develop an effective model for involving HCPAs in the planning of MNCH related activities

3.2.1 Presentation

The presentation on planning was made by Mrs Tahera Ahmed, Assistant Representative of the UNFPA country office in Bangladesh. Mrs Ahmed first provided an overview of the MNCH situation in Bangladesh, including a description of the mortality, fertility and coverage rates of key interventions such as antenatal care, skilled delivery, and postnatal care. She then reviewed underlying socio-cultural factors contributing to Bangladesh's high maternal mortality ratio such as the early age of marriage and first pregnancy and the lack of women in decision making roles. However, she noted that recent changes in Bangladesh's educational policies mandating universal primary education, women's access to micro-credit and employment opportunities, infrastructure improvements, and increased political commitment to safe motherhood may translate into improvements in maternal survival in the coming years.

After describing the six components of Bangladesh's National Maternal Health Strategy 2001-2010 – which was developed through a participatory process involving all key stakeholders including members of civil society – Mrs Ahmed described the successful partnership formed in 2001 between the government and the Obstetric and Gynecological Society of Bangladesh (OGSB) to establish the community skilled birth attendant program (CSBAP). Specifically, she explained that OGSB participated in the initial needs assessment conducted to determine the feasibility of training female health workers as CSBAs, was responsible for the launch and evaluation of the pilot program, and was highly involved in the scale-up of the training program to 40 districts by 2008.

In conclusion, Mrs Ahmed stressed that in order for HCPAs to play a role in planning, they must advocate for the development of a defined policy and a specific coordination mechanism for different MNCH interventions, and must engage in partnerships with other civil society members. She also noted that HCPAs need to take up the challenge of supporting government-promoted activities by becoming more involved in family planning projects, and working in underserved areas.

3.2.2 Panel

The panel discussion was chaired by Professor A.B. Bhuiyan, (OGSB). Panelists included Dr Latifa Farooq, Afghan Society of Obstetricians and Gynecologists (ASOG), Mrs Irshad Begum, Midwifery Association of Pakistan (MAP), Mr. Ajudey Prasad Shrestha, Nepal Pharmaceutical Association (NPA), and Dr Pramila Pradhan, Nepal Society for Obstetricians and Gynecologists (NESOG).

Dr Farooq explained that the ASOG plans on coordinating with the government by participating in task forces addressing issues related to family planning, antenatal, delivery, and postnatal care. Mrs Begum described the involvement of the MAP in the development and roll-out of Pakistan's community based skilled birth attendant training program in February 2005. Dr Pradhan listed the challenges faced by NESOG, ranging from lack of funds and poor governmental recognition to busy members unable to dedicate time to the association. He also described how an effective collaboration between IPASS and the government led to their involvement in the legalization of abortion. Finally, Mr. Shrestha highlighted the importance of better incorporating pharmacists into MNCH activities given their role in dispensing needed medications to combat major diseases impacting pregnant women and children.

Recommendations from the panel session:

- Pharmacist associations need to be better incorporated into joint HCPA activities. Curriculums need to be revised to promote greater understanding of the role pharmacists play in service delivery as well as in ensuring quality control of medications.
- To address the unequal distribution of health care workers:
    - security issues must be taken into greater consideration so that health care professionals are able to deliver services in hard to reach areas;
    - incentives such as increased training opportunities and greater remuneration need to be provided to health care professionals opting to work in remote locations and urban slums;
    - better supervision and management including improved communication need to be increased in rural areas.
- To decrease donor dependency and improve the sustainability of programs, governments need to be convinced of the importance of allocating greater funds to MNCH;
- Multi-constituency partnerships need to be established to better deliver services along the continuum of care. However, these partnerships need to be based on well defined objectives and clear delegation of responsibilities.
- HCPAs involved in planning should focus on monitoring and evaluation activities, the accreditation process, and curriculum review.
- Six values need to be considered when engaging in planning exercises for MNCH: customer satisfaction, quality of care, preserving the dignity of women and children, equity, benefits/returns to society, and compensation and remuneration.

3.3 Quality Improvement

3.3.1 Presentation

Dr Nighat Shah, Society of Obstetrics and Gynecology of Pakistan (SOGP), began her presentation by describing contextual and health system factors impacting MNCH in Pakistan such as the low contraceptive prevalence rate, high rate of miscarriages, gender inequities, and vertical programming. She then discussed the joint SOGP/FIGO Fistula project – explaining how this project shows that improvements in the quality of care can result in increases in the demand for and utilization of services. The fistula project began in 2006 and involved the provision of training opportunities in reproductive health, the rebuilding and equipping of a hospital, the hiring of nurses and doctors, and the delivery of services for free. Over time, a relationship based on trust has been established with the community as word has circulated about the quality of available care. Challenges faced by the program include dependence on donor funding (scheduled to run out in 2010), and lack of government ownership and involvement.

Dr Shah pointed to quality improvement as central to MNCH, and noted that the proliferation of different initiatives with changing targets presents a challenge to the consistent delivery of high quality services across the continuum of care. She stressed that improving the quality of care is a complex process requiring commitment and leadership from HCPAs and governments, regular funding, learning from best practices, and conducting initial needs assessments as well as routine monitoring and evaluation. She listed training, continuing education, supervision, standards of care, regulation and accreditation, and inter-HCPA partnerships as “quality enablers”.

3.3.2 Panel

The panel discussion was chaired by Mr Prafull Sheth, International Pharmaceutical Federation (FIP). Panelists included Dr Haleema Yasmin, Society of Obstetrics & Gynecology of Pakistan (SOGP), Dr Jaydeep Tank, Federation of Obstetric and Gynecological Societies of India (FOGSI), Mrs Shamsun Nahar, Bangladesh Nursing Council (BNC) and Professor Abdul Latif Sheikh, Society of Hospital Pharmacists of Pakistan (SHPP).

Dr Yasmin provided additional details on the Fistula project, including the introduction of a delivery kit for 600 rupees, and counseling services provided to women about how to care for themselves pre and post-treatment. Dr Latif brought up the major role of pharmacists in ensuring drug availability and drug quality by monitoring environmental and storage conditions. Dr Tank stressed that health care providers need adequate training on how to correctly prescribe medicines, and the concept of quality needs to become a part of the culture of HCPs by being integrated into curriculums. Referring to the lack of clearly defined roles for nurse-midwives in Bangladesh, Mrs Nahar explained how the inadequate management of existing human resources can decrease the quality of available care.

The panel made the following recommendations:

- Research is needed to develop strategies for increasing deployment of health worker to remote areas, as well as the quality of care available in these locations.
- Advocacy work is needed to convince governments of the importance of the quality of care throughout the health care system.
- Quality improvement requires increased management and a culture change across health care professionals.
- Accreditation, training and continuing education must be promoted.
- Special attention needs to be paid to ensuring the quality and availability of medicines.

Mr Sheth closed the session by reminding participants that quality improvement requires: Continuous improvement, Culture Change, and Quality Management.

3.4 Human Resources

3.4.1 Presentation

Dr Zulfiquar Bhutta presented on behalf of Dr Ali Akhtar Hakro, of the Ministry of Health of Pakistan. He described Pakistan's Lady Health Worker Program (LHWP) as a successful example of human resource management and task shifting. The program has trained 100,000 community health workers to provide a range of MNCH services including skilled delivery and postnatal care. While the program is managed at the national level, monitoring and training activities are conducted at the provincial level, and health workers are deployed to communities after completing training.

The LHWP includes a comprehensive training component with both classroom and in-field instruction. Participants are also able to take refresher courses. The program has resulted in reductions in stillbirths and maternal mortality, showing that improvements in maternal and newborn survival can be achieved without needing to produce more obstetricians. The program has also had a positive effect on care seeking behavior and access to skilled delivery care.

3.4.2 Panel

The panel was chaired by Dr Shereen Bhutta, International Federation of Gynaecology and Obstetrics. Panellists included Dr Heera Tuladhar, Nepal Society of Obstetrics and Gynaecology (NESOG), Jatinder Kaur, Society of Midwives of India, Dr Subhash Mandal, Indian Pharmaceutical Association and Dr Saleha Hamnawazada, Afghan Midwifery Association (AMA).

The panellists agreed that there is a severe shortage of all cadres of HCPs (pharmacists may be an exception) in the South Asian region. They also agreed that the role of pharmacists in MNCH related activities needs to be enhanced, and noted that declining enrolments in educational programs in the health care field and preferences to work in cities are two factors underlying the current deficit of health care workers in the areas of greatest need. Dr Tuladhar stated that although NESOG does not have the financial resources to increase the number of care providers; it provides ongoing training and skill revision to improve the capacity of existing human resources. Mrs Kaur cited the heavy workload of HCPs in India as compromising service quality. Dr Mandal stated that India produces a large number of pharmacists per year who should be more involved in the storing and distribution of medicines. Dr Hamnawazada emphasized the human resource challenge in Afghanistan, particularly the lack of female health workers because of restrictions on educational opportunities for girls. However, she also noted that while there were only 476 midwives in Afghanistan under the Taliban regime, there are now over 2000. The AMA is hoping to work closely with the Ministry of Health in the establishment of a midwifery program in Afghanistan, especially in the selection, recruitment, and training processes.

The panel and discussions yielded the following recommendations:

- Advocacy work at the community level to increase demand for services must target men and community leaders as well as women, particularly because of their frequent role as 'gate keepers';
- Increasing the quality of training for existing HCPs is an important first step in strengthening the health system. It is an easier, potentially more cost-effective objective to achieve in the short term than increasing the total number of HCPs;
- Supervision and clear role definition are key for all health workers;
- The increased use of pharmacists can result in improvements in the quality and availability of care. For example, in Tanzania pharmacists were trained to detect malaria and dispense appropriate medications accordingly;
- A functional referral system is crucial to ensure patients receive the appropriate level of care needed.

3.5 Advocacy

3.5.1 Presentation

Dr Saleh Rahman Rahmani, Afghan Pediatric Association (APA), presented on the role HCPAs can play as advocates for MNCH and the need for HCPAs to engage in dialogue with policy makers to help countries achieve MDGs 4 and 5. He began his presentation by reviewing the high maternal, infant, and child mortality statistics in Afghanistan and the coverage levels of key MNCH interventions, explaining that 85% of all services in Afghanistan are delivered by NGOs.

Dr Rahmani then described the first ever conducted national advocacy workshop held in Afghanistan in 2006 as a step forward to addressing the countries' low coverage rates of essential MNCH interventions such as antenatal and skilled delivery care. The outcomes of the workshop included a follow-up meeting among MNCH stakeholders (including HCPAs), the launching of a national "Safe Motherhood" day, and the implementation of an advocacy campaign. An aspect of this campaign included the development by the APA of pictorial training guides for community health workers on IMCI (which emphasized the importance of zinc and low osmolarity ORS for the treatment of diarrhea).

During the second half of his presentation, Dr Rahmani described the challenges HCPAs in Afghanistan face to contributing to the design of MNCH programs and policies including weak coordination and communication across HCPAs, lack of resources, and the disruptive effects of Afghanistan's current conflict situation. To address these challenges, Dr Rahmani stressed the need for HCPAs to develop networks for collaboration and the sharing of best practices, and to strengthen relationships with other MNCH stakeholders including the government, and the international community.

3.5.2 Panel

Mrs Clara Pasha, International Confederation of Midwives (ICM) chaired the panel on advocacy. Panelists included Mrs Jita Baral and Ms. Indu Thapa, Midwifery Association of Nepal (MAN); Dr Sayed Ali Shah Alawi, Afghanistan Pediatric Association (APA); and Dr Kurshid Talukder, Centre for Woman and Child Health (CWCH) and Bangladesh Pediatric Association (BPA).

Dr Alawi discussed the involvement of HCPAs in Afghanistan with the Ministry of Health, describing Dr Rahmani's (APA member) experience as the IMCI national focal point and his participation in the development of national guidelines and strategies for child health. He also agreed with Dr Rahmani about the HCPA Workshop serving as a good opportunity for the Afghanistan country team to learn how to effectively coordinate with the MOH and better advocate for MNCH. Mrs Baral and Ms. Thapa stressed the need for advocacy work to promote skilled birth attendance, and stated that efforts to further reduce maternal, newborn, and child mortality must remain a priority of the Nepalese government. Dr Talukder outlined some of the barriers impeding HCPA involvement in advocacy: lack of time of HCPA members, lack of a unified voice including on how resources should be allocated, and which issues should be prioritized. He suggested that greater involvement of the members in agenda setting may lead to increased ownership and increased participation of HCPAs in advocacy. Mrs Pasha wrapped up the panel session by describing the many advocacy related activities of the ICM, including the productive partnerships the ICM has established with other umbrella organizations such as FIGO, WHO, UNFPA, and the PMNCH.

The panel and discussions yielded the following recommendations:

- Many HCPA initiatives are currently donor driven rather than based on country needs. HCPAs should adopt a democratic structure promoting the involvement of members in agenda setting.
- HCPAs should establish partnerships at different levels to push forward an advocacy agenda, including: working closely with policy makers, the media, and other members of civil society such as NGOs, academic institutions, teachers, and parents as well as with regional and international associations.
- HCPAs can be involved in a broad spectrum of advocacy activities such as: advocating for increased training opportunities and resources for improvements in the health care infrastructure and the strengthening of HCPAs; producing print materials for wide-scale distribution; pushing for improvements in curriculum instruction for health care professionals, and liaising with reporters to raise greater awareness of specific MNCH issues.

3.6 International and Regional Associations

3.6.1 Presentation

The purpose of the session was to provide concrete examples of possible ways for HCPAs to collaborate and move the MNCH agenda in their respective countries and at a regional level forward. The presentation was given by Dr Shahida Zaidi, International Federation of Gynecology and Obstetrics. She began her presentation by remarking on the inverse relationship between density of health care providers and maternal and child mortality, and the need to address the human resource crisis in South Asia. She suggested that a short term strategy for dealing with this crisis is to increase the number of trained and well supervised community health workers capable of providing skilled delivery care. She recommended that HCPAs prioritize reducing inequities in coverage, advocating for greater political commitment to MNCH, and the more efficient use of existing resources. She also encouraged HCPAs to embrace the concept of the continuum of care as the guiding principle for inter-HCPA collaborative work, and to better incorporate anesthesiologist and pharmacists into collaborative activities. She concluded her presentation by spotlighting joint FIGO and ICM activities (e.g., statements on PPH) and the FIGO/SOGP project aimed at reducing maternal and perinatal mortality in rural Pakistan – using these examples to illustrate the positive impact collaborative efforts between HCPAs can have on improving MNCH.

3.6.2 Panel

The panel discussion was chaired by Dr Andres de Francisco, Special Advisor to the PMNCH. Panelists included Dr Shereen Bhutta, FIGO, Dr Panna Chowdhury, IAP, Mrs Clara Pasha, MAP, and Mr. Prafull Sheth, FIP.

Dr de Francisco opened the panel session by remarking on the importance of networking for the sharing of best practices and for joint decision making on priority actions related to the achievement of MDGs 4 and 5. He also noted that a key benefit of collaborations is the pooling together of the different strengths of the involved partners. He asked the panelists to reflect on why collaborative work is important.

Dr Choudhury discussed how collaborations can increase the capacity of associations that lack funding. As an example of this process, he described the exchanges between IAP and the Royal Pediatricians in the United Kingdom which resulted in the development of guidelines and publications. Mrs Pasha described the partnership established between WHO, FIGO and ICM to produce recommendations for the prevention of post partum hemorrhage. She also mentioned a UNFPA /ICM collaboration aimed at increasing the capacity of skilled birth attendance in 40 high maternal mortality countries.

Mr. Sheth highlighted the potential advantages of fostering collaborative HCPA activities to ensure better management and procurement of drugs. He described how the FIP works through its 109 member organization to ensure adequate medication management at global, regional and local levels. He also listed the alliances that the FIP has with other medical and nursing associations. Dr Bhutta stated that the numerous HCPAs in Pakistan would be more effective if they developed partnerships enabling them to benefit from each other's strengths and experiences. She told participants that it is important to first build ties at the national level, and then move towards collaboration at the regional and international levels (the opposite of what is currently happening). Finally, she encouraged HCPAs to consider collaborations as a means of more effectively accomplishing tasks related to MDGs 4 and 5, rather than remaining entrenched in their own agendas.

During the question and answer session the following steps were identified for establishing partnerships across HCPAs, and between HCPAs and the public sector:

1) defining the goals and objectives of the partnership, and;

2) identifying how each partner can best contribute to the achievement of these goals and objectives.

IV - Country Group Work

The aim of the group sessions was to bring the country teams together to develop a 'country action plan' consisting of joint activities that could be accomplished within the next one-two years. More specifically, the country teams were asked to identify feasible and measurable actions that would ideally result in the increased contribution of HCPAs to MNCH. Participants were asked to select activities that could be implemented with little or no external support.

The country group work was divided into four sessions. During the first session, country teams were assigned the task of arriving at consensus on two or three intervention areas (out of the five that were discussed in the panel and presentation sessions) that would serve as the basis of their action plan. They were given the following issues:

a. To define the problem(s) associated with each chosen area. Why is each area selected considered a top priority for your country?
b. How will capacity building efforts in these areas enable you to work together to contribute to the achievement of MDGs 4 and 5.
c. If you are able to successfully implement activities linked to these areas, who will benefit the most and how?

In the second session, the country teams were asked to agree on a maximum of three activities per intervention area. Participants were asked to:

a. select a maximum of three feasible activities you and your partners can accomplish within a one-two year time interval for each of your chosen topical areas. (Total of nine activities);
b. identify existing structures and opportunities that can help you accomplish each activity;
c. define the obstacles to achieving these activities and proposals to overcome them;
d. outline the responsibilities/specific tasks associated with each activity;
e. assign each responsibility/task to a focal person/organization;
f. estimate the time frame for accomplishing each activity; (This includes listing immediate next steps per activity, and steps that can be taken later during the two year time interval).
g. determine the amount of support (e.g., financial and in-kind contributions) required from international, regional, and national partners to accomplish these activities.

During the third session, country teams were instructed to select indicators to measure their success in implementing their action plans. The guidelines included:

a. choose indicators that can be used to measure how well you were able to carry out the immediate next steps outlined in your action plans;
b. choose indicators that can be used to measure your progress in achieving your action plan at year 1 and year 2 of its implementation.

In the final session, country teams reported on one intervention area included in their action plans. After receiving feedback from all participants, the country groups reassembled to revise and finalize their action plans. Each country's action plan is available in Annex 4; along with a summary of the process each country underwent to develop its action plan, and a case study of Bangladesh.

V - Conclusion

The series of Multi-Country HCPA Workshops supported by the PMNCH in conjunction with its Health Care Professional Advisory Group is an initiative aimed at strengthening the ability of HCPAs to contribute to the design and implementation of MNCH plans and policies. The South-Asia Multi-Country Workshop served as a catalyst for joint action across HCPAs in Afghanistan, Bangladesh, India, Myanmar, Nepal and Pakistan. It provided an opportunity for HCPAs in these six countries to forge important links, and to begin aligning activities aimed at improving MNCH at national and regional levels.

The Workshop enabled participants to share best practices and discuss possible solutions to common bottlenecks such as health care inequities, poor provider attitudes, and lack of community ownership and demand for services. Innovative projects for addressing the human resource crisis and quality of care issues, for example, were described (e.g., Lady Health Worker Program, and the Pakistan Fistula Project). The participation of donors and other MNCH stakeholders will also potentially result in greater support of HCPAs, including joint activities. Perhaps most importantly, the Workshop created a forum for country teams to come together and develop action plans that can realistically be achieved in the next one-two years. The implementation of these action plans will hopefully lead to continued collaborations among HCPAs in the six countries with measurable results.

Annexes

Annex 1 - Country action plan matrix

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Time frame (Q1)	Immediate next steps	Focal Person

Annex 2 – Summary of the Country Action Plans

The sophistication of the Bangladesh action plan indicates the level of advancement of the HCPAs in the country (see Annex 3).

The Afghanistan country team emphasized organizational strengthening in their action plan – on establishing a network of HCPAs, agreeing on common MDG 4 and 5-related goals, and identifying capacity building needs. They also focused on advocacy as a key strategy for raising awareness levels of MNCH in the community and among health care providers.

The India team focused on advocacy and quality improvement. The advocacy activities identified in their action plan included the promotion of increased collaboration between HCPAs, and between HCPAs and the government. Activities related to quality improvement involved working toward the incorporation of quality into training materials, curriculums, and standards of care.

The Myanmar team, represented by one participant, produced an action plan with a focus on quality improvement and human resources. Activities listed under human resources included increased opportunities for the training of trainers, increased and improved recruitment processes, and strategies to improve the distribution of health care providers. The activities linked with quality improvement centered on the development of training materials and guidelines to improve MNCH services. The representative from Myanmar was encouraged to determine other organizations that could work with his association on the implementation of the action plan.

The Nepalese team listed organizational strengthening and advocacy as the two areas of most importance in its action plan. The activities presented under organizational strengthening included ideas for increasing HCPA membership, the creation of a forum for HCPAs, and the development of a proposal for more training opportunities for the different cadres of MNCH health care professionals. Advocacy activities include raising the awareness of the government about the importance of developing an integrated MNCH plan, the need for more skilled birth attendants in underserved areas, and for greater recognition of pharmacists as important contributors to MNCH.

The Pakistan team identified organizational strengthening and advocacy as the two growth areas of most critical importance. The organizational strengthening activities consisted of convening a meeting of all HCPAs resulting in the signing of a Memorandu, of Understanding to work together on five priority areas addressing key gaps in the continuum of care. Advocacy activities included the development of joint work protocols.

The country action plans can be found in Annex 4.

Annex 3. Case study Bangladesh Country Group Work

The Bangladesh country group included representation from paediatric, nursing, obstetrics and gynaecology associations, the Ministry of Health, UNFPA, BRAC and WHO. It is important to mention that there is no midwifery association in Bangladesh. The group included presidents from three HCPAs and therefore had some facility in its decision making especially regarding the assignment of tasks to associations.

The group first began its discussions by agreeing that a national HCPA partnership for MNCH in Bangladesh needed to be created to facilitate common action. Participants decided, however, that this association should regroup all of the influential associations involved in MNCH. It was decided that the following 12 societies would be asked to join:

1. Obstetrics and Gynaecology Society of Bangladesh
2. Bangladesh Medical Association
3. Bangladesh Paediatric Association
4. Bangladesh Perinatal Society
5. Bangladesh Nurses Association
6. Bangladesh Breastfeeding Foundation
7. Nutrition Working Group
8. Pharmacists Association of Bangladesh
9. Bangladesh Neonatal Forum
10. Bangladesh Private Medical Practitioners Association
11. Bangladesh Medical Assistants Association
12. Bangladesh Anaesthesiologist Association

Having agreed on the need to form a partnership, the participants tackled the first task and identified three key intervention areas which they thought needed to be addressed in Bangladesh. Within those areas they listed the reasons for which these areas were so important to resolve. This took the shape of a list of issues needing to be addressed within each area. The issues were arranged based on priority. In some cases, identifying the hierarchy of needs resulted in the definition of some recommendations. The following describes the areas of intervention underlined by the key issues, and in some cases recommendations:

1. Advocacy
    i. lack of coordination in between the associations;
    ii. commitment of association to the continuum of awareness at professional level about the extent of the problems regarding MNCH issues;
    iii. advocacy towards the government;
    iv. awareness at top level;
    v. political commitment;
    vi. awareness at community level: poor health seeking behaviour

2. Human recourses
    i. shortage of human recourses (HR)
    ii. HR not in place or position

a. poor working conditions, including a lack of recognition, salary, incentives, low attendance, lack of job description and no managerial support;
b. midwifery training programme are shorter;
c. midwives are now multi purpose providers based at the hospitals.and involved with managerial and other works;
d. commitment is lacking from both health workers and the government;
e. existing CHWs of NGOs and HW of Govt. at community level need more training and supervision;

iii. Recommendations
a. fill vacant posts;
b. create new posts;
c. increase training;
d. government should increase supply of logistics;
e. improve follow-up and monitoring of the community health workers;
f. Involve community.

3. Quality Improvement:
i. Why providers do not provide quality services:
a. lack of logistics, supply;
b. lack of training, poor quality of training…therefore lack of confidence;
c. workload;
d. job description not defined;
e. poor supervision and monitoring;
f. lack of management support;
g. lack of incentives therefore commitment;
h. socialization of medical doctors and nurses in an environment which is not patient friendly.

ii. Why people are reluctant to receive services:
a. interventions not properly done;
b. lack of proper communication;
c. social taboos.

Group members then listed what they saw as opportunities existing in Bangladesh which may facilitate or form the basis for activities. The opportunities are as follows:

- cooperation between the HCPAs, the HCPA meeting as a first step towards networking;
- a national taskforce for MDGs 4 and 5 exists and is headed by the secretary for health. The government listens to the recommendations of the task force, some meeting participants are on the task force. The taskforce has an action plan which is being reviewed by the government;
- the maternal health strategy is to be updated soon, this provides and opportunity to integrate MNCH;
- there is a high number of NGOs working in the MNCH field, opportunity for collaboration;
- Saving Newborn Lives has a neonatal health strategy which is under review by the government;
- there are rural MNCH programs being run by BRAC and UNICEF and funded by DfID, AusAID and the Netherlands embassy;
- BRAC is implementing an urban slums MNCH program funded by Gates;
- there is a national nutrition program in place;
- there is IMCI;

- there is a skilled birth attendance program (existing government field workers being trained for 6 months for delivery care);
- there are over 5000 nurses who are waiting for jobs; they have not yet been placed by the government; they have two years of nursing training and one year of midwifery training;
- there is a health manpower review currently being conducted.

The agreement on the above issues, opportunities and recommendations yielded the following action plan.

Annex 4 Country action plans

Action Plan of HCPAs of Bangladesh

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Time frame	Immediate next steps	Focal Person
Advocacy	Formation of a CORE COMMITTEE of key executives of HCPAs	OGSB and BPA, BPS and BNA	Seed money from the Partnership	CORE COMMITTEE meeting held	By January 2009	Contact 12+ partner associations	Presidents of OGSB and BPA, BPS and BNA (Prof Sayeba Ahkter, Prof Abdul Hannan, Prof TA Chowdhury, Ms. Ira Dibra)
	Development of a concept paper with a proposed action plan for intra and inter association collaboration and brochure on the hoped structure and objectives of a Bangladesh multi-disciplinary HCPA group for MNCH	All HCPAs, UNFPA, UNICEF, WHO, MoHFW	Funding for a partnership consultant (2 years) to coordinate partners and develop documents (and coordinate workplan)	Concept paper, action plan and brochure are developed and agreed upon by all HCPAs	June	Contact potential donors for funding, draft terms of reference for consultant, office staff and logistics	Presidents of OGSB and BPA (Prof Sayeba Ahkter, Prof Abdul Hannan)
	Meeting of the executives of the national HCPAs to discuss a way forward for HCPA collaboration and get endorsement on the proposed concept note (which will	Members of the executive committee of all HCPAs and MoHFW present at	Funding for meeting	Concept note and action plan approved and disseminated, MoU signed, number of	July	Contact potential donors for funding, draft terms of reference for consultant, office staff and logistics	Presidents of OGSB and BPA (Prof Sayeba Ahkter, Prof Abdul Hannan)

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Time frame	Immediate next steps	Focal Person
	thereafter be circulated)	meeting (100 people maximum), UNFPA, UNICEF, WHO, MoHFW, BRAC		participants			
Human Resource	Lobby the Ministry of Health to approve the strategy entitled "Enhancing Contribution of Nurse Midwives for Midwifery services.."	All HCPAs, UNFPA, UNICEF, WHO, MoHFWFW	Advocacy support to the MoHFW	Ministerial approval of the strategy for Enhancing Contribution of Nurse Midwvies for Midwifery services	June	Lobby and make contacts	Registrar BNC - Ms. Shamsun Nahar
	Lobby the Ministry of Health to upgrade post of nurses	All HCPAs, UNFPA, UNICEF, WHO, MoHFWFW	Advocacy support to the MoHFW	Ministerial approval of the strategy for Enhancing Contribution of Nurse Midwvies for Midwifery services	June	Lobby and make contacts	Registrar BNC - Ms. Shamsun Nahar, Presidents of OGSB and BPA (Prof Sayeba Ahkter, Prof Abdul Hannan)
	Get representatives of the HCPA partnership on the health manpower review committee of the Ministry of Health under Chair-Additional Secretary	All HCPAs, MoHFW, UNFPA, UNICEF, WHO	Advocacy on behalf of HCPAs	Number of HCPAs able to join the review committee	January	Apply to the MoHFW for participation	Presidents of OGSB and BPA (Prof Sayeba Ahkter, Prof Abdul Hannan)
	Advocate to the Ministry of Health to fill up old and creates new posts working for MNCH (e.g. nearly 5000 nurses without govt. jobs among others)	All HCPAs, MoHFW, UNFPA, UNICEF, WHO	Advocacy on behalf of HCPAs	Number of new posts created or old posts filled	Full 2 years	Lobby and make contacts	Presidents of OGSB and BPA (Prof Sayeba Ahkter, Prof Abdul Hannan)

Action Plan of HCPAs of Afghanistan

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Time frame	Immediate next steps	Focal Person
organizational strengthening	Establishment of networking system by sharing information through email, coordination meetings, joint forum to facilitate an effective communication within national, regional and international HCPAs	APA,AMA,ASOG,AAP, ANA, HPA, government, MoPH, UN agencies	Technical Support from regional partners, approval required from government ,logistics and financial support of UN agencies and donor communities and bilateral agencies	meetings held monthly, MOU signed, plan developed	Q1,2009	Provide feedback to in-country HCPAs (each participants' respective organization) including the need to work together, sign MOU across HCPAs	Dr Rahmani (TBC)
	choose a shared goal related to MDGs 4 and 5 for all the associations	APA,AMA,ASOG,AAP, ANA, HPA, government, MoPH, UN agencies		shared goal developed	Q1 ,2009	Agree upon developing one MNCH plan, contact MNCH coordination committee	Dr Rahmani (TBC)
	to Identify the capacity building needs and enhance resources mobilization of each individual HCPA	APA,AMA,ASOG,AAP, ANA, HPA, government, MoPH, UN agencies	Support from government, logistics and financial support of UN agencies and bilateral agencies	Capacity building plan developed based on assessment of need, proposal developed for funding	Q2,2009	Charge each HCPA to 1. Evaluate their strengths and determine how they can contribute to the accomplishment of the plan, 2. Identify their leadership skills and training requirements	Head, of in country health associations,(TBC)

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Time frame	Immediate next steps	Focal Person
Advocacy	to increase awareness in the community for safe motherhood and danger sign during pregnancy and need for skilled care during entire maternity cycle for all pregnant women	APA,AMA,ASOG,AAP, ANA, HPA, government, MoPH, UN agencies	providing technical material by MOPH ,technical and financial support of UN agencies	advocacy plan developed, IEC material developed and distributed, plan implemented, utilization of available maternal health services increased at health facilities in 10 provinces	Q1-Q2 ,2009, Q1-Q2,2010	sharing result of regional meeting with MoPH and other partners, required approval of MoPH,	AMA, AFSOG and partners(to be confirmed)
	to introduce Zinc and low osmolarity ORS in private health sector	APA, AAP, ANA, HPA, MoPH, UN agencies	providing technical material by MOPH ,technical and financial support of UN agencies and donor communities and bilateral agencies	introduction plan developed ,plan implemented in 3 provinces (KBL, Nangarhar, Hirat)	Q2- 2009, ongoing to 2010	orientation of stakeholders ,mapping of the partners ,	APA and partners (to be confirmed)
	To advocate and promote health care providers regarding proper use of prototroph and active management of third stage of labor.	AMA, ASOG, AAP, ANA, HPA, government, MoPH,UN agencies	Technical Support of local and regional partners, approval required from government ,logistics and financial support of UN agencies	number of health care provider trained in prototroph and management of third stage of labored ,plane developed for training of health providers in KBL, Nangarhar, Hirat ,provinces	Q1 ,2009 ongoing to 2010	orientation of stakeholders and MOPH ,determine number of untrained health providers ,explore training opportunities through UN agencies, AKU	AMA, AFSOG and partners (TBC)

Action Plan of HCPAs of India

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Timeframe	Immediate next steps	Focal Person
Quality Improvement	Quality in public health sector needs urgent attention.		Document developed		Desktop research – available Government standards and desktop facility survey and compare with existing surveys.	Document developed	
	Fill the gaps with defined standards. With QCI.		Document developed			Document developed	
	Accrediting of PHC's and other public health facilities by the QCI.		Number of PHC's accredited	End 2010		Number of PHC's accredited	End 2010

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Timeframe	Immediate next steps	Focal Person
Advocacy	Fulfill the requirements for collaboration:		Funding	MOU	2008 December end	PMNCH to write to all the HQ's. and to WHO country office to be forwarded to the Ministry. 2. MOU between Partners	Prafull Sheth
	Country level meeting to develop the strategy with involvement of Government.		Funding	Document developed for Strategy	April – 2009	Each association to send advocacy data and plans for the forum - January Involve government. Commitment from Government.	Neelam and Prafull, Document Hiralal Konar, Jaydeep
	Ratification from Government to have the professional associations included in technical groups at all levels.		Funding	Ratification from Government	Mar-2010		

Action Plan of HCPAs of Myanmar (draft)

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Timeframe (Q1)	Immediate next steps	Focal Person
Quality Improvement	a)Provision of CME to doctors in private sector	CME project and INGO		numbers trained	one year	feedback	
	b) Development of evidence guidelines and intervention to improve MNCH services.	corresponding societies and UN agencies		production of guidelines	6 months	distribution of the guidelines	
	c) Development of training packages for conducting training for capacity building of health care providers.	corresponding societies and UN agencies		production of manual	one year	training	
Human resources	1.Recruiting right people to be deployed in right place	MMA		people trained	one year	give appropriate training	
	2.Training of trainers	corresponding society and INGO's		number trained	six months	dissemination of knowledge gained	
	3.Scaling up the performance of the medical doctors in remote areas.	Local branches of MMA		number trained	one year	provision of service	

Action Plan of HCPAs of Nepal

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Timeframe	Immediate next steps	Focal Person
Organizational strengthening	1. Establish a forum of existing HCPAs to promote working together for MDG 4 and 5	NMA, NESOG, NEPAS, NAN, NPA, ASN, PESON, PMA, PHA, NPA & related gov departments		MOU signed by all HCPAs, quarterly meeting minutes shared, email list of HCPA members as a networking tool	30-Dec-08	Participants will discuss with own professional organizations the workshop and the importance of working together	Dr RM Shrestha, Dr Heera
	2. Increase HCPA membership	NMA, NESOG, NEPAS, NAN, NPA, ASN, PESON, PMA, PHA, NPA & related gov departments)		Number of new members	ongoing	Determine how to inform other HCPs about the organizations, brainstorm about creating incentives for membership (e.g., training opportunities, forum for the sharing of experiences)	President of each HCPA
	3. Write proposal for training different cadres of MNCH health care professionals		Technical support of PMNCH	Draft of proposal, Submission of proposal	01-Mar-09	Assess training needs	Dr L Shrestha
Advocacy	1. Advocate for the gov to develop one MNCH plan	NMA, NESOG, NEPAS, NAN, NPA, ASN, PESON, PMA, PHA, NPA & related gov departments)	Financial support to convene an advocacy workshop from PMNCH and NGOs and INGOs	Workshop on advocacy strategy convened, joint statement and strategy developed, HCPA representative discusses	01-Jul-09	Organize an advocacy workshop	Dr Pramila Pradhan, Mrs Jita Baral

Priority areas of interventions	No more than 3 key activities for the next 1 -2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Timeframe	Immediate next steps	Focal Person
				statement with gov. officials			
	2. Advocate for an increase in the no. of SBAs in underserved areas		Technical support in developing advocacy tools from PMNCH and NGOs and INGOs	Baseline number of SBAs, increase in no. of SBAs in underserved areas, changes in the no of trained SBAs placed in MNCH services ONLY, increase in the number of training sites for SBAs (from 5-10)	30-Dec-09	Access data on the baseline number of SBAs and their locations, to conduct meetings with NHTC, SSMP, FHD	Ms. Sarala K. C./Ms. Indu Thapa
	3. Advocate about the important role of pharmacists in overall medication management to the gov		Approval and support to conduct baseline study of quality drug availability from logistic management division of MOH , technical and financial support from PMNCH and NGOs and INGOs	Availability of quality drugs related to MNCH in all facilities	01-Dec-09	Baseline study on current availability of quality drugs	Mr. Ajudey Prasad Shrestha

Action Plan of HCPAs of Pakistan

Priority areas of interventions	No more than 3 key activities for the next 1 - 2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Timeframe	Immediate next steps	Focal Person
Organizational Strengthening	Initial meeting of HCPA leadership in Karachi for agreement and signing of MOU. To be hosted at PMA House, Karachi	Main partner HCPAs in Pakistan (SOGP, PPA, MAP, PNF, PMA, SHPP, PSA, LHW program, MNCH program)	Funds arranged	Development of MOU and signing thereof	Preliminary meeting 30th December, 2008 Meeting of HCPA partners 17th January, 2009	HCPA members present to report back to member associations	Dr Salma Shaikh
	Agreement on 5 priority areas for intervention across continuum of MNCH and creation of a core working group in each HCPA for this 5 Star package) - Prevention and early diagnosis of pregnancy-induced hypertension, incl eclampsia - Reduction in occurrence of maternal hemorrhage - Promotion of clean, safe delivery - Reduction in incidence of birth asphyxia, and its improved management - Prevention of serious infections in the newborn and young infants (cord infections, pneumonia and diarrhea)	Main partner HCPAs in Pakistan (SOGP, PPA, MAP, PNF, PMA, SHPP, PSA, LHW program, MNCH program)	Agreement with umbrella HCPAs (IPA, FIGO, ICM, ICN, PMNCH etc). Agreement with evidence from Lancet series on MNCH and PHC	Development of core agreed packages for the 5 target areas Development of estimates for current coverage rates for relevant intervention indicators (with provincial and district level specificity) Development of intermediate indicators by concerned HCPA for intervention packages and coverage	To be developed in the first quarter of 2009	Creation of working groups in each HCPA and across organizations to agree on intervention packages (preventive and therapeutic) and develop common agreed protocols	

Priority areas of interventions	No more than 3 key activities for the next 1 - 2 year period	Associations and partners involved	Support needed from partners	Monitoring indicators	Timeframe	Immediate next steps	Focal Person
Advocacy	Development of agreed work protocols and interventions at various levels of care & their dissemination to relevant sectors.	Main partner HCPAs in Pakistan (SOGP, PPA, MAP, PNF, PMA, SHPP, PSA, LHW program, MNCH program) plus technical partners in UN agencies and bilateral (USAID, DFID, UN agencies) and relevant large national NGOs	Technical and financial support from UN agencies, national MNCH program and funding partners. Agreement on work plan for training and capacity enhancement by HCPAs at various levels	Development and publication of the following for each area 1. Detailed operational protocols and training manuals 2. List of core monitoring indicators for the 5 star package	To be developed by the end of the second quarter of 2009	Creation of working groups in each HCPA to collate and summarize existing evidence base on interventions for these areas and available relevant materials for adaptation/ further development	
	Development of an agreed joint statement and advocacy plan for members, MNCH program and civic society members for these major areas (5 Star Plan)	Main partner HCPAs in Pakistan (SOGP, PPA, MAP, PNF, PMA, SHPP, PSA, LHW program, MNCH program) + above and mass media (public and private)	Financial support from UN agencies, national MNCH program and funding partners. Funding from government health information cell and mass media representatives	As above	To be developed by the end of the second quarter of 2009	Collation and vetting of existing advocacy messages and materials for each of these areas in partnership with social marketing groups and mass media representatives	

Annex 5: Participants list

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